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1.0 Description of the Service

HIV case management is a service available that assists eligible recipients to gain access to needed medical assistance as described in the North Carolina State Medicaid Plan as well as to services not included in the State Plan. The goal of HIV case management services is to facilitate the recipient's medical, social, and educational needs.

HIV case management includes the following core service components: assessment, care planning, referral/linkage, and monitoring/follow-up. Refer to **Section 5.0** for definitions of the core service components.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service. The case management agency providing services is required to verify the recipient's eligibility and Medicaid coverage category.

2.2 Eligible Categories

2.2.1 Medicaid Card

Recipients with regular Medicaid identification (MID) cards may be eligible for HIV case management services.

2.2.2 Recipients with Medicaid for Pregnant Women Coverage

Medicaid for Pregnant Women (MPW) is limited to medical conditions related to pregnancy or complications of pregnancy. Pregnant women who are covered by MPW are eligible for HIV case management services due to the potentially adverse impact on the fetus and/or infant.

2.3 Ineligible Categories

2.3.1 Medicaid for Family Planning Waiver

Recipients who are covered by Medicaid for Family Planning Waiver benefits (regular MID card with the statement "Family Planning Limited" printed on the card) are not eligible for HIV case management services.

2.3.2 Medicare Qualified Beneficiaries

Medicaid recipients with Medicare Aid coverage are not eligible for HIV case management services.

Note: Refer to Section 2 of the ***Basic Medicaid Billing Guide*** (on DMA's Web site at http://www.ncdhhs.gov/dma/medbillcaguide.htm) for additional information on Medicaid eligibility.

2.4 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination**** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.
b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.
b. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid Billing Guide*:** http://www.ncdhhs.gov/dma/medbillcaguide.htm

EPSDT provider page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

3.0 When the Service Is Covered

Medicaid covers HIV case management services when all of the criteria specified in this section are met.

a. The service is medically necessary. Recipients must have a documented diagnosis of HIV disease or HIV seropositivity. Acceptable documentation shall include at least one of the following:
   1. confidential positive HIV test results using Ab testing;
   2. physician's statement;
   3. hospital discharge statement, or other medical report that verifies diagnosis; or
   4. copy of approval for participation in the North Carolina AIDS Drug Assistance Program (ADAP).

   Note: Infants (birth to 12 months) born to HIV-infected mothers can receive HIV case management services without regard to their HIV status.

b. The service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.

c. The level of service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide.

d. The service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

4.0 When the Service Is Not Covered

4.1 General Criteria

HIV case management services are not covered when one or more of the following criteria are met and/or when of any one of the criteria stated in **Section 4.2** are applicable:

a. The recipient does not meet the eligibility requirements listed in **Section 2.0**.

b. The recipient does not meet the criteria listed in **Section 3.0**.

c. The service duplicates another provider's service.

d. The service is experimental, investigational, or part of a clinical trial.

e. Services are not rendered in accordance with this policy.

4.2 Program Administration Criteria

Medicaid does not cover HIV case management services while a recipient is institutionalized in one of the following facilities:

f. general hospital, psychiatric hospital, nursing facility;

g. intermediate care facility for the mentally retarded (ICF-MR);

h. any form of incarceration; or

i. a halfway house that provides case management.

Note: HIV case management services may be provided on the day of admission or the day of discharge from a facility. These services shall not duplicate the responsibilities of the discharge planner.

The activities listed below are not covered HIV case management services. This listing is not all inclusive.

a. Institutional (hospital and nursing facility) discharge planning
b. Recipient outreach activities, such as contacting potential recipients
c. Direct services, such as transporting recipients or delivering food and medication
d. Activities that are deemed administrative expense, such as time spent in billing, writing progress notes, or attending supervisory conferences
e. Activities that are not specific to the recipient (that is, services directed to assist another family member)
f. Counseling and therapy services, including religious and pastoral care

5.0 Requirements for and Limitations on Coverage

Each core service component shall be fully documented within the recipient record.

Note: The HIV case management agency shall adhere to strict confidentiality rules and obtain necessary release of information per agency policy, state and federal regulations.

5.1 Assessment

HIV case managers shall screen and evaluate the prospective recipient's status to determine the need for initial case management services. This is accomplished through an information gathering and decision making process which includes intake and assessment.

HIV case managers collect, analyze, synthesize, and prioritize information in order to identify needs, resources, and strengths. At a minimum, each area identified below shall be addressed.

a. Socialization and recreational needs
b. Physical needs to include both activities of daily living and instrumental activities of daily living
c. Medical care concerns
d. Social and emotional status
e. Housing and physical environment status
f. Financial needs
g. Mental health/substance abuse/developmental disabilities needs

The case manager shall provide a copy of the assessment to the recipient's primary HIV health care provider and other relevant medical care providers.

5.2 Care Planning

This component builds on the information collected through the assessment process and specifies goals and actions to address the medical, social, educational, and other services needed by the eligible recipient. Care planning includes activities to ensure the active participation of the recipient and others in an effort to develop goals and to identify a course of action to respond to the assessed needs.

The care plan shall be completed with the initial assessment, at an annual reassessment, and as needed secondary to unanticipated events or changes in a recipient's status. The care plan shall be signed and dated by the case manager and recipient or the recipient's legally responsible representative.

The case manager shall provide a copy of the care plan to the recipient's primary HIV health care provider and other relevant medical care providers.

5.3 Referral/Linkage and Resource Development

This component includes making referrals, scheduling appointments and other activities that help link recipients to medical, social, and educational providers and to other programs and services identified in the plan of care.

5.4 Monitoring and Follow-up Activities

This component includes activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the recipient. Monitoring and follow-up are conducted as frequently as necessary to help determine whether

a. services are being furnished in accordance with the recipient's care plan;
b. services in the care plan are adequate; and/or
c. there are changes in the needs or status of the recipient, and if so, whether
    1. necessary adjustments have been made in the care plan and service arrangements with the providers and/or
    2. the recipient has been discharged, if appropriate.

Reassessments and discharges/terminations are examples of monitoring and follow-up activities.

5.4.1 Reassessments

The HIV case manager shall conduct a reassessment to determine the continued appropriateness of services and the continued need for services. The reassessment is conducted at least every 12 months and/or as needed secondary to unanticipated events or changes in the recipient's status. The assessment requirements are the same as those specified in **Sections 5.1** and **5.2,** Assessment and Care Planning. Care plan progress, changes, and mutually agreed-upon goals shall also be addressed in the care plan completed at reassessment.

The case manager shall provide a copy of the reassessment to the recipient's primary HIV health care provider and other relevant medical care providers.

5.4.2 Discharge/Termination

a. Reasons for termination include, but are not limited to, the following:
    1. recipient desires services from another case management agency secondary to relocation or recipient choice;
    2. recipient's goals met per the plan of care;
    3. recipient's unwillingness or refusal to participate in agreed-upon care plan;
    4. recipient's decision to terminate services;

5. lack of contact between recipient and case manager (case manager unable to contact recipient after repeated attempts over a three-month period);
6. recipient's abuse of staff, property, or services;
7. determination that recipient is HIV seronegative; and/or
8. recipient death.

b. The HIV case manager shall discharge or terminate the recipient from services through a systematic process, which shall include the following:
   1. written notification to the recipient of pending discharge at least seven business days in advance of discharge/termination.
   2. clear delineation of the reason(s) for discharge; and
   3. preparation of a written discharge summary, which shall be prepared and placed in the recipient's HIV Case Management record within four weeks of the final decision to terminate services.

c. The discharge summary shall include, at a minimum, the following:
   1. identifying information;
   2. referral and linkage to resources following discharge from HIV case management services;
   3. summary of services provided;
   4. reason and effective date of the discharge; and
   5. signature of case manager.

Note: The case manager shall provide a copy of the discharge summary to the recipient's primary HIV health care provider and other relevant medical care providers.

6.0 Providers Eligible to Bill for the Service

Providers who meet Medicaid's qualifications for participation and are enrolled with the N.C. Medicaid program to provide HIV case management services are eligible to bill for the service.

Provider agency types may include, but are not limited to, home health agencies, home care agencies, hospices, health departments, hospitals, departments of social services, federally qualified health clinics, rural health clinics, community-based organizations (CBO), and local management entities.

Agencies must be certified by the Division of Public Health (DPH) in order to be considered for enrollment with DMA as an HIV case management agency.

6.1 Certification Requirements

To qualify for reimbursement for HIV case management services, a provider shall meet all the criteria specified below.

a. Ensure the provision of HIV case management services by qualified case managers.

b. Ensure supervision of HIV case managers by qualified supervisors.

c. Enroll each physical site with DMA as a provider of HIV case management services in accordance with §1902(a)(23) of the Social Security Act.

d. Meet applicable state and federal laws governing the participation of providers in the Medicaid program.

e. Maintain DPH certification as a qualified provider of HIV case management services.

f. Demonstrate compliance with initial and ongoing certification processes.

g. Demonstrate compliance with the monitoring and evaluation of case management records through a quality assurance plan.

h. Allow DMA and/or DPH to review recipient records.

i. Notify DPH of proposed changes such as business owner or name change, address or telephone number change, or plans for business dissolution within 30 days of proposed change.

6.2 Division of Public Health Certification and Decertification Process

DPH is responsible for certifying qualified HIV case management providers to render services in accordance with professionally recognized standards and as specified by this policy, and also for decertifying those HIV case management agencies that fail to render services in accordance with professionally recognized standards and as specified by this policy.

6.2.1 Initial Certification

A provider shall comply with all the requirements specified below. The initial certification is valid for up to three years.

a. Submit a complete and signed application to DPH that includes

1. description of the core components described in **Section 5.0**;
2. quality assurance plan, including the monitoring and evaluation of case management records (see **Section 7.4**);
3. counties to be served;
4. hours of operation;
5. confidentiality policy;
6. recipient grievance policy;
7. non-discrimination policy;
8. code of ethics policy;
9. conflict of interest policy;
10. electronic records policy, if applicable;
11. HIV case management financial plan;
12. record retention policy;
13. recipient rights policy;
14. transfer and discharge policy;
15. identification of abuse, neglect and exploitation policy;
16. human resource policy to include validation of credentials, continuing education and criminal background check policy;

17. policy for assuring recipient's freedom of choice among providers; and
18. informed consent form.
19. plan for providing case management if the agency has insufficient case management staff to cover caseload.

b. Submit a copy of the agency's organizational chart.

c. Submit a list of owners who have five percent or more ownership.

d. Submit a copy of the agency's proposed recipient satisfaction survey.

e. Meet all the criteria stated below.

1. Have a physical business site at the time of application. **Note:** This site cannot be in a private residence or vehicle.
2. Have a list of potential community resources for the entire proposed service area.
3. Are incorporated , unless it is a local government unit.
4. Successfully complete a pre-certification site visit.
5. Meet all applicable state or federal licensure and certification requirements.
6. Employ qualified and trained case managers and supervisors, or contract with an agency or individual to provide case management or supervision who meets the qualifications as described in **Sections 6.3** and **6.4**.

Incomplete applications will be returned to the provider with no further action required by DPH.

6.2.2 Recertification

The recertification is valid for up to three years. To be recertified, a provider shall:

a. Submit a complete and signed application to DPH within the specified time frame.

b. Submit copies of all items in **Section 6.2.1** that have changed since the initial certification.

c. Submit copies of all HIV CM and supervisor credentials.

d. Submit documentation that recipient satisfaction surveys have been conducted annually.

Incomplete applications will be returned to the provider with no further action required by DPH.

6.2.3 Technical Assistance Site Visits

A newly certified agency will be provided with four technical assistance (TA) site visits, to be completed quarterly after the agency is certified. TA site visits may also be provided to investigate complaints. The TA site visits are initiated by DPH after the agency is certified and has admitted a recipient for case management. The purposes of the TA visit are to ensure that the agency is completing the core service components of care management according to the HIV Case Management policy, and to provide training and consultation.

Note: A referral to DMA Program Integrity will be made if DPH staff determine that the agency has hired non-qualified staff or if there is evidence of fraudulent billing.

6.2.4 Program Monitoring

If unmet program requirements are noted during any site visits, the provider shall submit a written plan of correction to DPH upon request within 30 days. Upon review of the corrective plan of action, Technical Assisted visits may be scheduled as deemed necessary by DPH to determine if corrective action has taken place.

6.2.5 Decertification

If any one of the following conditions is substantiated, the provider may be decertified by DPH and disenrolled by DMA. This list is not all inclusive.

a. failure to meet the case management needs of the recipient;
b. fraudulent billing practices;
c. failure to develop, submit, and implement a written plan of correction to resolve unmet program requirements cited by DPH and/or to make DPH-recommended corrections;
d. falsification of records;
e. violation of a recipient's confidentiality;
f. employment of staff who do not meet the criteria stated in **Section 6.3**;
g. failure of staff to attend the DPH mandatory basic training within three months of their employment date;
h. failure of staff to obtain required continuing educational units (CEU), as specified in **Section 6.4**;
i. failure to provide case management staff with supervision to meet the recipients' needs:
j. failure to submit any required documentation within the time frame designated by this policy and/or DPH;
k. failure to implement and enforce a quality assurance program;
l. failure to notify DPH of any changes in agency name, director/ownership, mailing address, and telephone number(s), resulting in DPH's or DMA's inability to contact the agency; and/or
m. failure to comply with all applicable federal and state laws, regulations, state reimbursement plan, and policies governing the services authorized under the Medicaid program.
n. failure of an agency to enroll any recipients within 12 months of certification

Note: When a provider agency is decertified by DPH, due process/appeal rights shall be issued to the provider agency.

6.3 Staff Qualifications

It is the responsibility of the provider agency to verify staff qualifications and credentials prior to hiring. Verification of staff credentials shall be maintained by the provider agency.

6.3.1 HIV Case Manager

An HIV case manager shall meet *one* of the following qualifications approved by DMA and DPH:

a. Hold a master's degree from an accredited college or university in a human services field, including, but not limited to, social work, sociology, child development, maternal and child health, counseling, psychology, or nursing.

b. Hold a bachelor's degree from an accredited school of social work.

c. Hold a bachelor's degree from an accredited college or university in a human services field or related curriculum, including at least 15 semester hours in courses related to social work, counseling, or public health; and have six months of social work or counseling experience.

d. Hold a bachelor's degree from an accredited college or university and have one year of experience in counseling or in a related human services field that provides experience in techniques of counseling, casework, group work, social work, public health, or human services.

e. Be licensed, if applicable, by the appropriate licensure board in North Carolina as a registered nurse, nurse practitioner, physician, physician assistant, or certified substance abuse counselor and have two years of experience working in human services.

Note: A standard year of work experience is calculated at 2080 hours per calendar year. An accredited educational institution is one that is nationally recognized. Refer to a regional accreditation organization or the U.S. Department of Education Web site at http://www.ed.gov.

6.3.2 HIV Case Manager Supervisor

An HIV case management supervisor shall meet one of the following qualifications approved by DMA and DPH:

a. Hold a master's degree from an accredited college or university in a human services field, including, but not limited to, social work, sociology, child development, maternal and child health, counseling, psychology, or nursing; and one year of human services experience.

b. Hold a bachelor's degree from an accredited school of social work and have two years of human services experience.

c. Hold a bachelor's degree from an accredited college or university in a human services field or related curriculum, including at least 15 semester hours in courses related to social work or counseling and have two years of experience in human services or public health.

d. Hold a bachelor's degree from an accredited college or university and have either three years of human services experience or two years of human services experience plus one year of supervisory experience.

e. Be licensed, if applicable, by the appropriate licensure board in North Carolina as a registered nurse, nurse practitioner, physician, physician assistant, or certified substance abuse counselor; and have either three years of human services experience or two years of human services experience plus one year of supervisory experience.

Note: The agency shall identify the HIV case manager program supervisor within the organization.

6.3.3 Contract Staff

Providers may elect to contract with qualified case managers and supervisors. The same qualifications described in **Sections 6.3.1** and **6.3.2** are required of both employees and contractors.

6.4 Training Requirements

6.4.1 Training for Case Managers and Supervisors

All HIV case managers and case manager supervisors shall complete state-sponsored, basic policy training within three months of their employment date. It is the responsibility of providers to retain copies of certificates of completion issued by DPH.

Upon successful completion of the basic training, the case manager or supervisor will be able to do all of the following:

a. describe basic HIV information and prevention techniques;

b. describe the scope of work for case managers;

c. identify and explain the core components of HIV case management;

d. demonstrate an understanding of basic ethical issues relating to case management; and

e. demonstrate an understanding of the responsibilities and functions of the HIV case manager system of care.

6.4.2 Annual Training

All HIV case managers and supervisors are required to attend 20 hours annually of continuing education related to HIV case management. It is the responsibility of providers to retain copies of certificates of completion.

6.5 Requests to Expand

Provider agency expansion requests shall meet each of the following criteria:

a. Expansion requests for additional county coverage shall be submitted to DPH.

b. A new physical site shall be obtained if the area listed in the expansion request is more than 60 miles from the agency's existing office.

Note: This site cannot be in a private residence or vehicle.

c. If establishment of a new site is required, at least one case manager shall be designated for the new site. Case managers covering the expansion area shall meet the qualifications described in **Section 6.3**.

d. The provider shall enroll with Medicaid for any new site. A separate provider number will be issued.

e. The agency is meeting recipients' needs as evidenced by having received no significant citations over the past 12 months related to care delivery

f. The agency is compliant with all applicable federal and state laws, regulations, state reimbursement plan, and policies governing the services authorized under the Medicaid program.

Incomplete expansion applications will be returned to the agency and no further action shall be required by DPH.

7.0 Additional Requirements

7.1 Coordination of Care

The HIV case manager shall facilitate coordination of service delivery when multiple providers or programs are involved in care provision in order to ensure the appropriate use of resources, recipients' freedom of choice, and the avoidance of duplication of efforts and services. HIV case management recipients may not receive other case management services that are Medicaid reimbursed, including the following:

a. Community Alternatives Programs (CAP), including, CAP for disabled adults (CAP-DA), CAP for children (CAP/C), and CAP for the mentally retarded/developmentally disabled (CAP-MR/DD) and CAP Choice.

b. At-risk case management for adults and children who are at-risk of abuse, neglect, or exploitation

c. Child service coordination, a case management program for children under age five

d. Maternity care coordination, a case management program for pregnant women

e. Targeted case management for the mentally retarded or developmentally disabled

Payments for targeted case management may not duplicate payments under other program authorities (such as child welfare and foster care services).

7.2 Transfer

HIV case management agencies shall have written policies governing transfers between case management providers. The receiving agency may elect to

a. accept the recipient as an ongoing recipient and accept copies of all of the previous agency's forms (with the exception of the consent forms, which must be obtained upon transfer); or

b. accept the recipient as a new recipient and complete all new forms.

Both providers are expected to work towards a smooth transition by

a. planning a transition date;

b. communicating with local department of social services Medicaid staff when transitioning between counties; and

c. completing a discharge summary before transitioning between providers.

7.3 Recipient Record Documentation Requirements

7.3.1 Record Retention

All HIV case management providers shall keep and maintain all Medicaid financial, medical, and other records such as policies and quality assurance activities, etc., necessary to fully disclose the nature and extent of services furnished to Medicaid recipients and claimed for reimbursement. This shall include the historical documentation of all corrections made to assessments and plans of care. These records shall be retained for a period of not less than five

years from the last date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements.

The provider shall promptly retrieve the records and make them available for review by DMA or agents acting on behalf of DMA for claims review, audit, medical record review, or other examination during the retention period specified above. Should a case management agency close, the agency must provide the following information in writing to DPH within 30 calendar days of the closing date:

a. physical location of the records (hard copy and electronic);
b. name of contact person;
c. contact person's telephone number.

7.3.2 Documentation Requirements

At a minimum, the provider shall maintain the following documents within the recipient's record:

a. intake forms and proof of HIV status;
b. assessments;
c. care plans;
d. progress notes*****;
e. medication sheet;
f. contact sheets for resource development and coordination of service delivery;
g. discharge notification and discharge summary, as applicable; and
h. recipient consent form(s) that address release of information, consent for case management, and recipients' rights and responsibilities.

*Progress notes shall include the following, at a minimum:

a. the place of service delivery;
b. the date of service;
c. the nature, extent, and duration of time, to include the start and end time of the activity, in addition to the number of minutes or units;
d. the case manager's signature, including first and last name with title or initials (if applicable) indicating licensure and/or certification;
e. statements that reflect individualized care;
f. quarterly updates in the care plan at ; and the list of service providers updated at least every three months;
g. a list of all contacts, both direct and indirect, with the recipient;
h. a list of all contacts with the recipient's support network, providers, and other participants in the plan of care.

7.3.3 Documentation Time Frame Requirements

a. The initial assessment shall be completed within seven business days of the referral date. Annual reassessments shall be conducted at least every 12 months and as needed secondary to unanticipated events or changes in the recipient's status.

b. The care plan shall be completed within seven business days of the assessment completion date.

c. Progress notes shall be documented and incorporated into the record within seven business days.

d. The contact sheet, which details a list of all service providers, family contacts, and other informal support persons, shall be completed with the care plan and reviewed and updated as needed, at least every three months.

e. The recipient shall be contacted within 30 calendar days of the care plan completion date to monitor the recipient’s progress. Thereafter, at least one contact with the recipient, recipient’s support network, providers, and other participants, shall be made and documented at least every three months.

f. The care plan shall be reviewed at least every three months. Changes shall be made as needed, and documented.

g. Each recipient shall be surveyed annually to assess satisfaction with case management services and coordination.

h. A written notice of termination or change in HIV case management services shall be forwarded to the recipient at a minimum of seven business days.

i. Any deviations from the above (a through h) must be documented in the progress notes.

7.3.4 Electronic Records

An HIV case management provider may store clinical records, including those documents referenced in **Section 7.3.2**, electronically (i.e., on disk, microfilm, or optical imaging systems). Providers using electronic storage systems are subject to the following recordkeeping requirements.

a. Electronic clinical records and electronic billing documentation must be kept for a minimum of five years.

b. The provider shall promptly retrieve the records and make them available for review by DMA or agents acting on behalf of DMA for claims review, audit, medical record review, or other examination during the retention period specified above. Upon request, the provider shall supply electronic copies of all the signed documents referenced in **Section 7.3.2** to support services billed to the Medicaid program.

c. With respect to claims review, audit, or other examination, clinical records shall be presented along with the equipment necessary to read them.

d. The provision for storing records electronically does not remove the requirement for retaining records for five years from the last date of service. Providers unable to maintain the historical documentation electronically shall maintain hard copies for the specified retention period.

e. All documentation with electronic signatures must be consistent with state regulations (GS § 66-58.5) and the provider agency's policy.

7.4 Quality Monitoring

The HIV case management agency shall develop and implement an internal quality assurance policy and program. The policy shall, at a minimum, address the following:

a. the person who is responsible for the quality assurance program;

b. method to review ten percent sampling of records at least every three months;

c. the procedure to develop a corrective action plan for identified problems; and

d. the procedure for follow-up to ensure that identified problems have been corrected.

8.0 Policy Implementation/Revision Information

Original Effective Date:

Revision Information:

Date	Section Revised	Change

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in Medicaid managed care programs.

A. Claim Type

Agencies enrolled to provide HIV case management services bill the N.C. Medicaid program using the CMS-1500 claim form. Claims may also be submitted electronically.

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity. Providers must use valid ICD-9-CM diagnosis codes for recipient's diagnosis related to HIV disease, HIV seropositivity, or CDC-defined AIDS.

C. Procedure Code(s)

Only procedure code T1017, Targeted Case Management Services (HIV), is used for billing HIV case management.

D. Reimbursement

Providers must bill their usual and customary charges.

One unit of service equals 15 minutes.

Providers must accept Medicaid payments for HIV case management services as payment in full.

HIV case management cannot be billed on the same day as any Community Alternatives Program (CAP) service including CAP/Choice. This also applies to behavioral health case management, child service coordination, maternity care coordination and at-risk case management for adults or children.

HIV case management cannot be billed when a recipient is institutionalized, excluding the date of admission and the date of discharge. See **Section 4.2**.

E. Place of Service

Acceptable places of service include offices, and the recipient's home. Recipients may also reside in adult care homes.